CHAPTER 35-000 REHABILITATIVE PSYCHIATRIC SERVICES

35-001 Introduction: The Nebraska Medical Assistance Program (NMAP) covers rehabilitative psychiatric services to rehabilitate clients experiencing severe and persistent mental illnesses in the community and thereby avoid more restrictive levels of care such as inpatient psychiatric hospital or nursing facility. Rehabilitative psychiatric services for children age 20 and younger are covered under EPSDT treatment plans, as described in Chapter 32-000 of this Title. Rehabilitative psychiatric services for adults age 21 and older are covered under the rules and regulations of this chapter. The services must be medically necessary and biopsychosocially appropriate and the most appropriate level of treatment for the individual client. This does not include treatment for a primary substance abuse diagnosis.

35-001.01 Admission and Discharge Criteria: ~~Definition of Severe and Persistent Mental Illness:~~

35-001.01A Admission Criteria: Medicaid covers rehabilitative psychiatric services for those persons disabled by severe and persistent mental illness and who are able to benefit from the service. Rehabilitative psychiatric services must be prior authorized by the Department or designee. To be eligible for rehabilitative psychiatric services, a client must be experiencing a severe and persistent mental illness as defined by the following: ~~Clients with severe and persistent mental illness must meet the following criteria:~~

1. The client is age 21 and over;
2. The client has a primary diagnosis of schizophrenia, major affective disorder, or other major mental illness under the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Developmental disorders~~,~~ or psychoactive substance use disorders may be included if they co-occur with the primary mental illnesses listed above;
3. The client has a persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with or limits the client's ability to function independently in an appropriate and effective manner in two of three functional areas: Vocational/Education, Social Skills, Activities of Daily Living.
   a. Functional limitations in the area of Vocational/Education abilities are defined as:
      (1) An inability to be consistently employed or an ability to be employed only with extensive supports, except that a person who can work but is recurrently unemployed because of acute episodes of mental illness is considered vocationally impaired;

(2) Deterioration or decompensation resulting in an inability to establish or pursue educational goals within a normal time frame or without extensive supports;
(3) An inability to consistently and independently carry out home management tasks, including household meal preparation, washing clothes, budgeting, and child care tasks and responsibilities;

b. Functional limitations in the area of Social Skills and abilities are defined as:
(1) Repeated inappropriate or inadequate social behavior or an ability to behave appropriately or adequately only with extensive or consistent support or coaching or only in special contexts or situations, such as social groups organized by treatment staff; or
(2) Consistent participation in adult activities only with extensive support or coaching and when involvement is mostly limited to special activities established for persons with mental illness or other persons with interpersonal impairments; or
(3) A history of dangerousness to self or others.

c. Functional limitations in the area of Activities of Daily Living are defined as an inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community, in three of five areas listed below:
(1) Grooming, hygiene, washing of clothes, and meeting nutritional needs;
(2) Care of personal business affairs;
(3) Transportation and care of residence;
(4) Procurement of medical, legal, and housing services; or
(5) Recognition and avoidance of common dangers or hazards to self and possessions.

4. The client is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed mental health services are not provided, and this pattern has existed for ~~one year~~ 12 months or longer and is likely to endure for one year or longer; and
5. The client does not have a primary diagnosis of substance abuse/substance dependency, ~~or~~ developmental disabilities, personality disorder, or dementia.

35-001.01B Discharge Criteria In Support of a Recovery Philosophy: Providers of Rehabilitative Psychiatric services must consider the client for discharge when there has been an improvement in the client's level of functioning, a stabilization of risk for relapse, and a decrease in symptomatology. Specific criteria to consider for each service domain are listed in those sections.

35-001.02 Definition of Medical Necessity: To be covered by Medicaid, rehabilitative psychiatric services must be medically necessary and biopsychosocially appropriate. NMAP considers biopsychosocial necessity to be a further clarification of medical necessity. A client receiving rehabilitative psychiatric services must be disabled by a severe and persistent mental illness and the services must meet the following medically necessary and biopsychosocially appropriate criteria. ~~The NMAP uses the following definition of medical necessity:~~

Medically necessary and biopsychosocially appropriate treatment interventions and supplies are those which are:

1. Consistent with the behavioral health condition and conducted with the treatment of the client as the primary concern;
2. Supported by sufficient evidence to draw conclusions about the treatment intervention's effects of behavioral health outcomes;
3. Supported by evidence demonstrating the treatment intervention can be expected to produce its intended effects on behavioral health outcomes;
4. Supported by evidence demonstrating the intervention's intended beneficial effects on behavioral health outcomes outweigh its expected harmful effects;
5. Cost effective in addressing the behavioral health outcome;
6. Determined by the presentation of behavioral health conditions, not necessarily by the credentials of the service provider;
7. Not primarily for the convenience of the client or the provider; and
8. Delivered in the least restrictive setting that will produce the desired results in accordance with the needs of the client.

Behavioral health conditions are the diagnoses listed in the current version of the Diagnostic and Statistic Manual as published by the American Psychiatric Association. For this chapter, the primary diagnosis is limited to those diagnosis which are defined as severe and persistent mental illness. The NMAP does not reimburse for services for primary diagnoses of developmental disabilities, mental retardation, substance abuse, developmental disorders, dementia or V codes as part of this chapter.

Behavioral health outcomes means improving adaptive ability, preventing relapse or decompensation, stabilization in an emergency situation, or resolving symptoms, sustaining community-living.

~~"Health care services and supplies which are medically appropriate and -~~

1. ~~Necessary to meet the basic health needs of the client;~~
2. ~~Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;~~
3. ~~Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;~~
4. ~~Consistent with the diagnosis of the condition;~~
5. ~~Required for means other than convenience of the client or his or her physician;~~
6. ~~No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;~~
7. ~~Of demonstrated value; and~~
8. ~~No more intense level of service than can be safely provided.~~

~~The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Medicaid. Services and supplies which do not meet the definition of medical necessity set out above are not covered."~~

For purposes of covering rehabilitative psychiatric services under this Chapter, all ~~the following interpretative notes apply. M~~medically ~~necessity~~ necessary and biopsychosocially appropriate services ~~for rehabilitative psychiatric services includes:~~ must reasonably be expected to increase or maintain the level of functioning in the community.

~~Health care services which are medically appropriate and -~~

1. ~~Necessary to meet the psychiatric rehabilitation needs of the client;~~
2. ~~Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;~~
3. ~~Consistent in type, frequency, duration of service with accepted principles of psychiatric rehabilitation;~~
4. ~~Consistent with the diagnosis of the condition;~~
5. ~~Required for means other than convenience of the client or his or her service provider(s);~~
6. ~~No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;~~
7. ~~Of demonstrated value; and~~
8. ~~A no more intense level of service than can be safely provided.~~

~~For the purpose of this Chapter, rehabilitative psychiatric services are medically necessary when those services can reasonably be expected to increase or maintain the level of functioning in the community of clients with severe and persistent mental illness.~~

35-001.03 Staff Requirements: Staff providing rehabilitative psychiatric services such as residential rehabilitation, day rehabilitation, and community support must meet the following minimum standards:

1. Have demonstrated skills and competencies in working with people experiencing severe and persistent mental illness;
2. Have completed a staff training curriculum for initial orientation and continuing education prepared by the agency and has been approved by the Department or designee;
3. Licensed staff provide services as identified within their scope of practice; and
4. All program staff are available to provide services as defined in each individual section of this chapter.

~~35-001.03A Staff Position Descriptions and Specific Requirements:~~

Specific staffing requirements and staff to client ratios are described in each service specific section.

35-001.04 Assessment and Evaluation: Clients receiving Community Support, Day Rehabilitation, or Residential Rehabilitation services must be assessed and evaluated according to the following regulation.

35-001.04A Pre-Authorization/Referral Screening: A thorough pre-authorization screening must be completed by the Department or their designee prior to referring the client for admission to a rehabilitative psychiatric service. The pre-authorization screening is based on the review of information provided by the referring entity and this information will be given to the provider as part of the referral for admission.

35-001.04B Comprehensive Assessment: A Comprehensive Assessment must be initiated and completed by the Community Support staff assigned to work with the client within 15 days after the client's admission to the rehabilitative psychiatric service, according to the following requirements.

1. Each assessment area must be completed by a staff member with skill and knowledge in the area being assessed, consistent with the progress requirement as identified in each service description. The assessment must be based upon all available information, including client self-reports, reports of family members and other significant parties, written summaries from other agencies, including police, courts, and outpatient and inpatient facilities, interviews with the client, and standardized assessment materials. A separate Comprehensive Assessment must be completed for each rehabilitative psychiatric service a client receives.
2. A complete biopsychosocial assessment must be completed for each client upon entrance/admission of the individual to the service, and on an individual basis as determined by the service description and the program's rehabilitation/clinical practice policy. The assessment must include a review of referral information and, through appropriate evaluation procedures, must supplement this information as needed for initiation or continuation of treatment and/or rehabilitation. Areas covered in the assessment must be consistent with program requirements as specified in the service description and are determined by the needs of the client served as well as the service mission of the program. If the client demonstrates needs that fall outside the scope of the service, referral to and cooperation with other appropriate services/programs must be demonstrated and documented.

35-001.04C The assessment must be completed within the timeframe specified in the rehabilitative service's policies and procedures, however, no more than 30 days. The assessment must include the following components:

1. Provider demographics including: provider name, address, phone, fax, and e-mail contact information;
2. Client name, Medicaid number identified, and other demographic information of the client that is relevant;
3. Presenting problem, chief complaint including: external leverage to seek evaluation, date when client was first recommended to obtain an evaluation, and synopsis of what led the client to schedule this evaluation;
4. Medical history, dental, and other health needs, medication and medication adherence history (History of medication usage and adherence or compliance)
5. Work/School/Military History;
6. Alcohol and drug history summary including frequency and amount, drug and alcohol of choice, history of all substance use/misuse/abuse, use patterns, positive intentions of drug use, consequences of use (physiological, legal, interpersonal, familial, vocational, etc.); periods of abstinence – when, and why, tolerance level, withdrawal history and potential, influence of living situation on use; other addictive behaviors, such as problem gambling; IV drug use; prior substance abuse evaluations and findings; prior substance abuse treatment, and client's family chemical use history;
7. Screening for current substance use, problem gambling, or other addictive behaviors;
8. Legal history;
9. Family/Social/Peer History;
10. Psychiatric/Behavioral History including previous mental health diagnoses and prior mental health treatment;
11. Collateral Information (Family/Friends/Criminal Justice);
12. Critical information for the gender-specific assessment of all women including:
    a. Children's custody and living situation;
    b. Children's use of substances;
    c. Domestic violence and sexual assault, body image, self esteem;
    d. Health/medical history, including gynecological, pregnancy, STDs, HIV status, tuberculosis (TB), hepatitis C, and current medications;
    e. Housing, including stability of current housing situation;
    f. Parenting knowledge and skills;
    g. Trauma and abuse;
    h. Self harm; and
    i. History of sex trade (sexual history).
13. Other diagnostic/screening tools, scoring and results, if determined to be appropriate;
14. Clinical impressions including: strength-based, recovery-oriented, trauma-informed summary information: Client strengths, goals, priorities, and motivation; input from family/parents/significant other/guardian/team members; psychosocial stressors; pertinent findings related to physical health; summary of clinical evaluation with diagnostic impressions as identified in the DSM;
15. Recommendations for service(s) to be provided by the program to address the client's needs; the recommendations must include co-occurring issues, including other behavioral health needs.

35-001.04D Individual Treatment and Recovery Plan: Each treatment/rehabilitation record must contain a recovery-oriented individualized plan for all services provided in the program based on the assessment of client strengths, service needs, and the service descriptions in this chapter. This plan must:

1. Be oriented towards the principles of recovery – inclusion, meaningful participation, and a life in the community of one's choosing;
2. Be reflective of best practices;
3. Include the client's individualized goals and expected outcomes;
4. Contain prioritized objectives that are measurable and time-limited;
5. Describe therapeutic methods to be used in achieving the goals and objectives that are recovery-oriented, trauma-informed, strength-based, and encourage evidence-based outcomes and reflect best practices;
6. Identify staff responsible for implementing the therapeutic methods;
7. Specify the planned frequency or duration of each therapeutic method;
8. Delineate the specific criteria to be met for discharge or transition to a lower level of care;
9. Include a crisis, relapse prevention, and/or recovery/wellness plan that includes strategies to avoid crisis or admission to a higher level of care;
10. Include the signature of the client and/or parent/guardian, and other pertinent documentation and agreement to the individual treatment and recovery plan;
11. Include health care proxy and trauma safety form;
12. Document that the individual treatment and recovery plan is completed within the timeframe specified in the policies and procedures;
13. Document that the plan has been reviewed, updated, and revised with client involvement. If documentation shows that the plan is not working, timely revision of the plan must be documented.
14. The plan and all updates must be signed by the licensed clinical supervisor.

35-001.05 ~~Transition~~Recovery and Discharge Planning: Throughout a client's care and whenever the client is transferred from one level of care to another, recovery and discharge planning must occur and be documented. The focus on recovery and discharge planning is to focus on helping the client become as functional as possible and be able to reside in as independent a setting as possible by facilitating a timely recovery to the appropriate level of rehabilitative service. Psychiatric Rehabilitative service providers are responsible for recovery and discharge planning.

Providers must meet the following standards regarding recovery and discharge planning:

1. Recovery and discharge planning must begin on admission to the service;
2. Discharge planning must be a component of the Treatment and Recovery Plan and consistent with the goals and objectives listed;
3. Recovery and discharge planning must address the client's needs for ongoing services to maintain gains and to continue as normal functioning as possible following discharge, support recovery;
4. Discharge planning must include identification of and clear transition into appropriate supportive services after discharge;
5. Providers must make or facilitate referrals and applications to the next level of care, and/or community support services;
6. Providers must arrange for the prompt transfer of clinical records and information to ensure continuity of care;

7. A written recovery and discharge summary must be provided as part of the clinical record; and
8. The client and family members or guardian (as appropriate) must be included in all phases of recovery and discharge planning; This participation must be clearly documented in the clinical record.

35-001.06 Clinical Documentation: Rehabilitative psychiatric service providers must maintain a clinical record that is confidential, complete, accurate, and contains up-to-date information relevant to the client's care and services. The record must sufficiently document assessments, treatment and recovery plans and plan reviews, important provider discussion, and client contacts describing the nature and extent of the services provided, such that a clinician unfamiliar with the service can identify the client's service needs and services received. The absence of appropriate, legible, and complete records may result in the recoupment of previous payments for services. Each entry must identify the date, beginning and end of time and location of service, and identify by name and title the staff person entering the information.

Clinical records must be written legibly or typed. If three separate individuals cannot understand the information written in a record because of handwriting that is difficult to read, the provider will risk recoupment of payment to Medicaid.

Clinical records must be maintained at the provider's headquarters. Records must be kept in a locked file when not in use. For purposes of confidentiality, disclosure of treatment information is subject to all the provisions of applicable State and Federal laws. The client's clinical record must be available for review by the client (and his/her guardian with appropriate consent) unless there is a specific medically indicated reason to preclude this availability. The specific reason must be documented in the clinical record and reviewed periodically.

35-001.06AThe clinical record must include, at a minimum:

1. Client identifying data, ,including demographic information and the client's legal status;
2. Assessment and Evaluations;
    a. Pre-Authorization/Referral Screening
    b. Comprehensive Biopsychosocial Assessment
    c. Admission Assessment for each appropriate service
    d. Psychiatric evaluation substantiating the client's diagnosis, and referred for rehabilitation service; and
    e. Other appropriate assessments.
3. Client's Diagnostic Formulation (including all five axes);
4. Treatment and Recovery Plan and updates to pla;
5. Documentation of the reviews of the Client Rights with the client;
6. A chronological record of all services provided to the client. Each entry must include the staff member who performed the service received. Each entry includes the date the service was performed, the duration of the service (beginning and end time), the place of the service, and the staff member name and title that provided the service;

7. Documentation of the involvement of family and significant others;
8. Documentation of recovery and discharge planning;
9. A chronological listing of the medications prescribed (including dosages and schedule) for the client and the client's response to the medication;
10. Documentation of coordination with other service and treatment providers;
11. Discharge summaries from previous levels of care;
12. Discharge summary (when appropriate); and
13. Any clinical documentation requirements identified in the specific service.

35-001.07 Clients' Rights: Individual staff and the treatment team must provide all services in a manner to support and maintain client's rights with a continuous focus on client empowerment and movement toward recovery. Psychiatric Rehabilitative Service Providers will have written Client Rights and Responsibility policy and staff will review client rights, responsibilities, and grievance procedures with each new client at admission and on an ongoing manner, and will document this review in the clinical record. Psychiatric Rehabilitative Service providers shall comply with all State and Federal Clients' Rights requirements.

The following rights apply to clients receiving psychiatric rehabilitation services through NMAP. The client has the right to:

Be treated with respect and dignity regardless of state of mind or condition;
Have privacy and confidentiality related to all aspects of care;
Be protected from neglect; physical, emotional or verbal abuse; and exploitation of any kind;
Be part of developing an individual treatment and recovery plan and decision-making regarding his/her mental health care;
Refuse treatment or therapy (unless ordered by a mental health board or court);
Receive care which does not discriminate and is sensitive to gender, race, national origin, language, age, disability, and sexual orientation;
Be free of any sexual exploitation or harassment; and
Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed.

35-001.08 Inspections of Care (IOC): The Department or its designee may periodically inspect the care and treatment services provided to clients in each type of service. The Inspection of Care team will include staff who are knowledgeable about mental health and rehabilitative psychiatric services and may include consumers and/or Department consultants.

The purpose of the Inspection of Care is to assess compliance with NMAP regulations and provide technical assistance to providers.

The activities of the Inspection of Care may include, but are not limited to:

1. Review of clinical documentation;
2. Client interviews;
3. Program review with provider staff;
4. Review of physical plant; and
5. Review of provider policy and procedures.

After an Inspection of Care, the IOC team will develop a report summarizing the findings of the visit. If deficiencies are noted, providers must submit a plan of correction.

~~35-002~~35-001.09 Provider Participation: To participate in NMAP as a provider of rehabilitative psychiatric services, a program must be ~~certified by the Department of Public Institutions under the applicable rules and regulations described in 204 NAC~~ enrolled as a Nebraska Medical Assistance Program provider according to the Medicaid regulations. ~~The provider shall agree to contract with the Department of Public Institutions for the provision of rehabilitative psychiatric services, and demonstrate the capacity to fulfill all the contractual requirements contained therein.~~ The provider must ~~also~~ complete and sign Form MC-19 ~~or Form MC-20~~, "Medical Assistance Provider Agreement," and be approved for enrollment in NMAP. In addition, eligible providers must also provide other documentation requested. Providers must notify Medicaid and/or its designee of any substantive changes in the programs or staff provided. Providers may be required to provide annual or regular updates of program information to determine ongoing compliance with NMAP regulations. Providers must maintain documentation of policies and procedures that meet the standards and regulations described in this chapter.

35-001.10 Medicaid Managed Care Program: Please refer to 482 NAC for information on the Nebraska Medical Assistance Managed Care Program.

~~35-003 Nebraska Health Connection Services: Certain Medicaid clients are required to participate in the Nebraska Medicaid Managed Care Program (known as the Nebraska Health Connection). The Department developed the NHC to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health services in a way that is cost effective to the State. The NHC was implemented on July 1, 1995. Enrollment in the NHC is mandatory for certain clients in designated geographic areas of the state. NHC clients may receive the NHC ID Document or the Nebraska Medicaid Card. Participation in NHC can also be verified by contacting the Nebraska Medicaid Eligibility System (NMES) (see 471-000-124) or electronically using the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).~~

~~The NHC utilizes two models of managed care plans to provide the basic benefits package; these models are health maintenance organizations (HMO's) and primary care case management (PCCM) networks. The NHC also provides a mental health and substance abuse benefits package on a statewide basis available to all clients who are required to participate in NHC.~~

~~If a client is required to participate in the NHC, all services contained in the benefits package (MH/SA or medical) must be provided under the management of the managed care plan.~~

35-001.11 Treatment Authorization: All Rehabilitative Psychiatric Services must be authorized by the Department or its designee. This may include prior authorization and continued stay reviews. Referrals for Rehabilitative Psychiatric Services must be directed to the Department or its designee and must follow established protocols for prior authorization and utilization management.

~~35-005 Referrals for Rehabilitative Psychiatric Services: Referrals for Rehabilitative Psychiatric Services will be directed to the Department or its designee. The referral must include documentation that establishes:~~

~~1. The client's Medicaid eligibility; and~~
~~2. How the client meets the definition of serious and persistent mental illness specified in 471 NAC 35-001.01.~~

~~35-006~~35-001.12 Eligibility for Rehabilitative Psychiatric Services: To be eligible for Rehabilitative Psychiatric Services as described in this chapter, the client must:

1. B~~b~~e eligible for Medicaid~~,~~;
2. M~~m~~eet the definition of severe and persistent mental illness~~,~~; and
3. B~~b~~e authorized by the Department or its designee for specific services.

~~35-007 Service Needs Assessment and Rehabilitative Psychiatric Service Recommendations: All clients determined eligible for rehabilitative psychiatric services must be assessed and have rehabilitative psychiatric service recommendations developed by a referring provider according to specified protocols.~~

~~35-008 Service Authorization: The completed assessment and rehabilitative psychiatric service recommendations must be reviewed by the Department or its designee. A determination will be made to -~~

~~1. Approve the client for a specified level and duration of one or more rehabilitative psychiatric services;~~
~~2. Request additional information from the assessor; or~~
~~3. Deny the request for rehabilitative psychiatric services.~~

~~35-009 Plan Development: Clients authorized for one or more of the rehabilitative psychiatric services (Community Support, Day Rehabilitation, Residential Rehabilitation) will be referred by the Department or its designee to the appropriate rehabilitative psychiatric services provider(s), consistent with client choice. Rehabilitative psychiatric service providers will be responsible for working with the client to -~~

~~1. Complete an assessment of the client's strengths and needs in that service domain according to the requirements of 204 NAC 5 004.05G and 204 NAC 5 004.05H2.~~
~~2. Develop, in conjunction with the client, an Individual Service Plan (ISP) for their respective service areas, according to the requirements of 204 NAC 5 004.05I.~~
~~3. Participate in developing, along with the client, the client's family members and/or significant others (as appropriate and with client consent), and other relevant community service providers, the client's Individual Program Plan (IPP) according to Department of Health and Human Services specified protocols.~~

~~35-010 Utilization Management: The Department or its designee will provide utilization management for all rehabilitative psychiatric services. This will include the service authorization/service intensity functions identified in 471 NAC 35-008. In addition, the Department or its designee will authorize client IPP's and provide ongoing utilization review of the client's progress in relation to the IPP's. At least annually, clients in rehabilitative psychiatric services will be reassessed and new service recommendations will be reviewed and approved by the Department or its designee as described in 471 NAC 35-008.~~

~~35-011~~35-001.13 Payment for Rehabilitative Psychiatric Services: ~~For services provided on or after April 1, 1995,~~ NMAP pays for rehabilitative psychiatric services at established rates. Rates will not exceed the actual cost of providing rehabilitative psychiatric services.

Procedure codes and rates of reimbursement for rehabilitative psychiatric services are part of the Nebraska Medicaid Practitioner Fee Schedule. The Department reserves the right to adjust procedure codes and the fee schedule to comply with other coding systems, establish new procedure codes, or adjust the fee schedule.

In general, the Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year. The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

35-001.13A Billing Requirements: Providers of rehabilitative psychiatric services must submit all claims for services on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic health care claim, professional transition (ASC X 12N 837) (see claim submission table 471-000-49).

~~35-012~~35-001.14 Appeals and Fair Hearings: A client has the right to appeal under 465 NAC 2-001.02 and 42 CFR 431, Subpart E. A provider has the right to appeal under 471 NAC 2-003. Hearings are conducted according to 465 NAC 6-000 and 42 CFR 431, Subpart E.

~~The Department of Public Institutions is primarily responsible for the administrative duties of this function.~~

35-001.15 Limitations: Reimbursement for services described in this chapter is subject to the following limitations.

1. All services must be authorized and medically and biopsychosocially necessary.
2. If a client is participating in Assertive Community Treatment Services, reimbursement is not available for any other psychiatric rehabilitative service and other outpatient mental health treatment described in 471 NAC 20. In limited situations, clients may receive ACT services for up to thirty (30) days prior to their discharge from a psychiatric residential rehabilitation program when the coordination of both services will facilitate the immediate return of the client to a community living situation; or
3. Reimbursement is available for Community Support Services for up to thirty (30) days prior to the client being discharged from the Psychiatric Residential Rehabilitation program.
4. If a client is participating in Day Rehabilitation Services, reimbursement is also available for Community Support Services.

~~35-004~~35-001.16 Covered Services: NMAP covers the following rehabilitative psychiatric services ~~under the rules and regulations of~~ in this chapter:

1. Community Support;
2. Day Rehabilitation;
3. Psychiatric Residential Rehabilitation; and
4. Assertive Community Treatment.

Unless otherwise stated, the introductory information in 471 NAC 35-001 applies to all rehabilitative psychiatric services.

~~For the purposes of meeting the requirements of 471 NAC 35-002, programs certified by the Department of Public Institutions under 204 NAC 5 (effective date December 19, 1994) as Residential Support and/or Service Coordination providers shall be considered to be certified as Community Support providers.~~

~~35-004.01~~ 35-002 Community Support: The Community Support program is designed to:

1. Provide/develop the necessary services and supports to enable clients to reside in the community;
2. Maximize the client's community participation, community and daily living skills, and quality of life;
3. Facilitate communication and coordination between mental health rehabilitation providers that serve the same client; and
4. Decrease the frequency and duration of hospitalization.

Community support must provide~~s~~ client advocacy, ensure~~s~~ continuity of care, support~~s~~ clients in time of crisis, provide~~s~~/procure~~s~~ skill training, ensure~~s~~ the acquisition of necessary resources and assists the client in achieving community/social integration. The community support program must provide~~s~~ a clear locus of accountability for meeting the client's needs within the resources available in the community. The role(s) of the community support provider may vary based on client's needs. ~~Community support is generally provided in the client's place of residence or related community locations.~~ Community support is a service in which most clients contact typically occur outside the program offices in community locations consistent with individual client choice/need. The frequency of contact between the community support provider and the client is individualized and adjusted in accordance with the needs of the client.

Community Support is a separate and distinct service, and may not be provided as a component of other Rehabilitative Psychiatric or Mental Health Outpatient Services except as described in 471 NAC 35-001.15 Limitations. Agencies that provide more than one level of rehabilitative psychiatric or Mental Health Outpatient Care must have staff dedicated to the Community Support program. These Community Support staff must not provide any other rehabilitative psychiatric or treatment service to the client.

~~35-004.01A~~ 35-002.01 Program Components: The Community Support program ~~shall~~ must –

1. Facilitate communication and coordination among the mental health rehabilitation providers serving the client;
2. Ensure the completion of a comprehensive strength-based psychosocial assessment, conducted by appropriately credentialed individuals within 30 days of admission for each client served to identify needed services and resources (for additional requirements related to assessments, see 471 NAC 35-001.04).
~~2.~~3. ~~Facilitate~~ Ensure the ~~development~~ completion of an Individual ~~Program Plan (IPP)~~ Treatment and Recovery Plan for each client served. The initial Individual Treatment and Recovery Plan must be completed within 30 days following the admission of the client and reviewed and updated every 30 days thereafter while receiving services. The Individual Treatment and Recovery Plan must be based on the results of a comprehensive assessment and is developed through an interdisciplinary team process. The Individual Treatment and Recovery Plan must include methods and ~~that includes~~ interventions to address: activities of daily living, community living skills, budgeting, education, independent living skills, social skills, interpersonal skills, psychiatric emergency/relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, physical health care, vocational/educational: services, resource acquisition, and other related areas as necessary for successful living in the community. (For additional requirements for Individual Treatment and Recovery Plans, see 471 NAC 35-001.04D).

4. Develop a plan that encompasses the supportive/rehabilitative interventions that will be directly provided by the Community Support Program;
5. Ensure the provision of services/interventions identified in the Treatment and Recovery Plan as the responsibility of other rehabilitative service providers;
6. Develop and implement strategies to ensure the client becomes engaged and remains engaged in necessary mental health treatment and psychiatric rehabilitation services;
7. Provide service coordination and case management activities, including coordination or assistance in accessing medical, social, education, housing, transportation or other appropriate support services as well as linkage to other community services identified in the Individual Treatment and Recovery Plan.
8. Facilitate communication between the treatment and rehabilitation providers and with the primary/supervising practitioner serving the client.
3. ~~Directly provide/procure the necessary individualized support and rehabilitative interventions to address client needs in the areas of: community living skills, daily living skills, interpersonal skills, psychiatric emergency/relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, substance abuse services, and other related services necessary for successful living in the community;~~
~~4.~~ 9. Monitor client progress in the services being received and ~~facilitate~~ participate in the revision ~~to~~ of the Treatment and Recovery Plan ~~Individual Program Plan~~ as needed;
~~5~~10. Provide contact as needed with other service provider(s), client family member(s), and/or other significant people in the client's life to facilitate communication necessary to support the individual in maintaining community living;
~~6~~11. Develop, evaluate, and update the crisis and relapse prevention plan and pProvide therapeutic support and intervention to the client in time of crisis. ~~and, i~~If hospitalization is necessary, facilitate, in cooperation with the inpatient treatment provider, the client's transition back into the community upon discharge. The Community Support program must be the client's primary source for support and intervention during times of crisis.
12. Participate in Individual Treatment and Recovery meetings and report to the treatment/rehabilitation team on the progress of the client in areas of medication compliance, relapse prevention, social skill acquisition, application, education, substance abuse, and ability to sustain community living.
13. Monitor medication compliance; and
14. Shall assist the client in Share of Cost eligibility issues and any other health insurance issues.

35-002.02 Admission and Discharge Criteria for Community Support Services

35-002.02A Admission Criteria: Community Support Services must be prior authorized by the Department or its designee. To be eligible for Community Support Services, the client must meet all of the criteria described in 471 NAC 35-001.01A and the following Community Support specific criteria:

1. The client currently has an identified severe and persistent mental illness under the current edition of the DSM;
2. The client is experiencing 2 or more functional deficits as defined in 471 NAC 35-001.01A that are expected to respond and improve with skill development and interventions;
3. The client requires active skills development, assistance and support maintain stable community living; and
4. The client is medically and psychiatrically stable and requires a low or moderate need of external professional structure.

35-002.02B Discharge Criteria: In addition to the criteria described in 471 NAC 35-001.01B, a client must be considered for discharge from Community Support services when he/she meet the following criteria:

1. The rehabilitation plan goals and objectives are substantially met and the client is able to self manage most of the objectives listed on the Individual Treatment and Recovery Plan.
2. The client has demonstrated sustained stable community living without active rehabilitation interventions and supports.
3. The client has a low to moderate risk to relapse.
4. The crisis/relapse prevention plan is in place and the client is no longer dependent on Community Support staff for support.
5. The client is experiencing a low to moderate need for external professional structure.

35-002.03 Staffing Standards: Community Support providers must meet the minimum staffing standards (see 471 NAC 35-001.03).

35-002.03A Direct Care Staff: The Community Support program must have a 1:20 staff to client ratio of Community Support staff.

35-002.03B Clinical Staff: Through employment or contract, the Community Support program must have the following clinicians available:

1. Clinical Supervisor: The clinical supervisor must participate in Treatment and Recovery Plan development and provide clinical supervision, consultation, and support. The clinical supervisor must work with the program at least four hours per week.
2. Other Consultants: Consultation by appropriately licensed professionals on general medical, psychopharmacology, and psychological issues, as well, as overall program design must be available and used as necessary.

35-002.04 Program Availability: The Community Support Program must ~~7.E~~ establish hours of service delivery that ensure program staff are accessible and responsive to the needs of the client. Scheduled services ~~shall~~ must include evening and weekend hours. The Community Support Program must ~~8.D~~ directly provide or otherwise demonstrate that each client has on-call access to a mental health provider on a 24 hour, 7 days per week basis.

35-002.05 Contacts: The frequency of contact between the client and the Community Support provider must be individualized and adjusted in accordance with the needs of the consumer. Community Support providers must ensure that the amount of direct contact is sufficient to meet the client's needs as identified in the Community Support ISP. Contacts may either be direct client contact or collateral contact.

1. Direct Client Contact. Direct contacts with the client that focus on the development of skills or the management of other activities identified on the Individual Treatment and Recovery Plan. Most contacts must occur in community settings. These face to face contacts must occur at a minimum of 3 times per month. Providers must document situations in which face-to-face contacts were scheduled but did not occur.
2. Collateral Contact. Collateral contacts are defined as contacts of 15 minutes or more which occur outside the provider organization without the client present and are related to the client's Individual Treatment and Recovery Plan. Collateral contact time must not constitute more that 25% of the contact time provided to the client each month.

35-002.06 Clinical Documentation: Community Support providers must follow the clinical documentation requirements listed in 471 NAC 35-001.06.

~~35-004.02~~ 35-003 Day Rehabilitation: The Day Rehabilitation program is designed to-

1. Enhance and maintain the client's ability to function in community settings; and
2. Decrease the frequency and duration of hospitalization. Clients served in this program receive rehabilitation and support services to develop and maintain the skills needed to successfully live in the community. Day Rehabilitation is a facility-based program.

~~35-004.02A~~ 35-003.01 Program Components: The Day Rehabilitation program shall provide:

1. ~~Prevocational~~ Educational and vocational services including services designed to rehabilitate and develop the general skills and behaviors needed to prepare the client to be employed and/or engage in other related substantial gainful activity. The program does not provide training for a specific job or assistance in obtaining permanent competitive employment positions for clients.
2. Community living skills and adult daily living skills development.
3. ~~Client skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms.~~Psychoeducational programming focused on relapse prevention, nutrition, daily living skills, social skills building, community living, substance abuse, medication education and self administration, and symptom management.
4. Social skills development through p~~P~~lanned socialization ~~and skills training~~ and recreation activities focused on identified rehabilitative needs.
5. Skill building in the ~~usage~~ use of public transportation and/or assistance in accessing suitable local transportation ~~to and from the Day Rehabilitation program~~.
6. Supportive services, referrals, and problem identification and solution focused outcome service coordination (primarily coordination with all physicians and medical services for general, medical, psychopharmacological and psychiatric services (as necessary).

35-003.01A Assessments: Day Rehabilitative Service providers must complete a strength based biopsychosocial assessment within 30 days of client's admission according to the requirements in 471 NAC 35-001.04. Ongoing assessment regarding progress and crisis and relapse prevention are also required.

35-003.01B Treatment and Recovery Planning: Day Rehabilitative Service providers must complete the initial treatment and recovery plans developed with the client, within 30 days following admission of the client according to the requirements in 471 NAC 35-001.04D. Review and adjustment of the treatment and recovery plan must occur with the client a minimum of every 30 days to meet the individual medical and rehabilitative needs of each client. The discharge plan must be discussed and documented at each interval, including admission. Treatment and Recovery Team Meetings must occur a minimum of every 30 days to discuss progress, adjust treatment approaches, identify problems and discuss solutions, as well as to coordinate the Day Rehabilitation program with other services.

~~35-004.02B~~ 35-003.01C Supportive Services: The program provides the following supportive services for all active clients: referrals, problem identification/solution, and coordination of the Day Rehabilitative program with other services.

35-003.02 Admission and Discharge Criteria

35-003.02A Admission Criteria: Day Rehabilitation Services must be prior authorized by the Department or its designee. To be eligible for Day Rehabilitation Services, the client must meet all of the criteria described in 471 NAC 35-001.01A and the following Day Rehabilitation specific criteria:

1. The client must have a DSM (current version) diagnosis identifying a severe and persistent mental illness.
2. The client has 2 or more functional deficits expected to improve with skill development interventions.
3. The client demonstrates moderate symptomotology.
4. The client is experiencing a low to moderate need of external professional structure.
5. The client has low to moderate risk of harm to self or others.
6. The client has moderate risk of relapse.
7. The client requires weekly to monthly review/adjustments of treatment/rehabilitation plan.

35-003.02B Discharge Criteria: In addition to the criteria described in 471 NAC 35-001.01B, clients must be considered for discharge from Day Rehabilitation services when they meet the following criteria:

1. The risk for harm and relapse has been stabilized/contained to be managed at lesser level of care.
2. The client is experiencing an improvement in functional deficit areas.
3. The rehabilitation plan goals and objectives have been substantially met.
4. The client demonstrates low risk of harm to self or others.
5. The client is experiencing a low need for external professional structure.
6. The client is able to self manage most of the objectives listed on the Integrated Individual Treatment and Recovery Plan with low risk for relapse.
7. Attendance is minimal.
8. Skill development may be sustained through supportive services.

35-003.03 Staffing Standards: Day Rehabilitation providers must meet the minimum staffing standards (see 471 NAC 35-001.03).

35-003.03A Direct Care Staff: The Day Rehabilitation program must have an overall 1:6 staff to client ratio for direct care staff.

35-003.03B Additional Staff: Through employment or contract, the Day Rehabilitation program must have the following consultants available:

1. Clinical Supervisor. The clinical consultant must participate in an Individual Treatment and Recovery Plan development and provide clinical supervision, consultation, and support. The clinical consultant may also participate in client assessment. The clinical consultant must work with the program at least four hours per week.
2. Other Consultants. Consultation by appropriately licensed professionals on general medical, psychopharmacology, and psychological issues, as well as overall program design must be available and used as necessary.

35-003.04 Program Availability ~~6.~~ The Day Rehabilitation program must provide a ~~A~~ scheduled availability of program services to clients for a minimum of five hours per day, five days per week. Specific services for each client must be individualized, based on client needs. The program must be able to schedule evening and weekend hours to meet individualized client needs. The Day Rehabilitation program must ~~7.~~ directly provide or otherwise demonstrate that each client has on-call access to a mental health provider on a (24) hour, (7) days per week basis. The access to a mental health provider must be documented on the client's Individual Treatment and Recovery Plan.

35-003.05 Clinical Documentation: Day Rehabilitative Service providers must follow the clinical documentation requirements listed in 471 NAC 35-001.06.

35-004~~.03~~ Psychiatric Residential Rehabilitation: Psychiatric Residential Rehabilitation is a facility-based, non-hospital or non-nursing facility program for persons disabled by severe and persistent mental illness, who are unable to reside in a less restrictive residential setting. These facilities are integrated into the community, and every effort ~~is made~~ must be for ~~these residences~~ those residents to approximate other homes in their neighborhoods. The Psychiatric Residential Rehabilitation program provides skill building and other related psychiatric rehabilitation services as needed to meet individual client needs. Psychiatric Residential Rehabilitation is a transitional service from a higher, more restrictive level of care to independent community living. The length of stay must generally not exceed 24 months. The client's Individual Treatment and Recovery Plan must always be focused on returning the client to independent living in the community. The Psychiatric Residential Rehabilitation Program is designed to:

1. Increase the client's functioning so that s/he can eventually live successfully in the residential setting of his/her choice, capabilities and resources;
2. Decrease the frequency and duration of hospitalization.

35-004.01 Program Components: The psychiatric residential rehabilitation program provides a minimum of twenty-five (25) hours of on-site psychosocial rehabilitation and skill acquisition activities per week. The program must facilitate client driven activities as appropriate. The residential rehabilitation program must provide the services identified on the client specific Individual Treatment and Recovery Plans. The activities must include, but are not limited to:

1. Ongoing assessment.
2. Arranging for general medical, psychopharmacological and psychiatric services, as necessary.
3. A minimum 25 hours per week of on-site psychosocial rehabilitation activities and skill acquisition.
4. Programming focused on relapse prevention, nutrition, daily living skills, social skill building, community living, substance abuse, medication education and self-administration, and symptom management.
5. Pre-vocational, Educational and vocational focus as needed.
6. A minimum of 20 hours per week of additional off-site rehabilitation, vocational and educational activities.

35-004.01A Assessments: Residential Rehabilitation Service providers must complete a comprehensive mental health and substance abuse screening and/or evaluation prior to admission. Following admission, a comprehensive strength-based biopsychosocial evaluation must be completed within 30 days of admission to assess the client according to the requirements described in 471 NAC 35-001.04.

35-004.01B Individual Treatment and Recovery Planning: Residential Rehabilitation Service providers must develop an Individual Treatment and Recovery Plan with the client that includes discharge planning within 30 days following admission. Thereafter, the plan must be reviewed and revised with the client, discussing and documenting the discharge plans a minimum of every 30 days according the requirements described in 471 NAC 35-001.05.

35-004.01C Supportive Services: The program provides the following supportive services for all active clients: referrals, problem identification/solution, and coordination of the Residential Rehabilitation program with other services the client may be receiving.

35-004.02 Admission and Discharge Criteria

35-004.02A Admission Criteria: Residential Rehabilitation Services must be prior authorized by the Department or its designee. To be eligible for Residential Rehabilitation Services, the client must meet all of the criteria described in 471 NAC 35-001.01A and the following Residential Rehabilitation specific criteria:

1. The client is experiencing moderate to severe symptomatology related to DSM (current version) diagnosis identifying a severe and persistent mental illness.
2. The client is unable to reside in less restrictive residential setting and requires 24/7 supervision.
3. The client demonstrates a moderate risk of harm to self or others.
4. The client has a moderate to high risk of relapse.
5. The client has long-standing severe psychiatric functional disorder amenable to active rehabilitation and treatment.
6. The client is high risk of re-hospitalization without 24 hour supervision.

35-004.02B Discharge Criteria: In addition to the criteria described in 471 NAC 35-001.01B, clients should be considered for discharge from Residential Rehabilitation services when he/she meet the following criteria:

1. The risk for harm and relapse is stabilized and contained to be managed at a lesser level of care.
2. Skill development may be sustained through supportive services.
3. The client demonstrates decrease in duration and frequency of psychiatric hospitalization.
4. The client is experiencing increased functioning to allow successful residential living with less supervision.

35-004.03 Staffing Standards: Psychiatric Residential Rehabilitation providers must meet the minimum (see 471 NAC 35-001.03).

35-004.03~~B~~A Licensure Requirements: The program ~~shall~~ must be licensed as a ~~Residential Care Facility, Domiciliary, or~~ Mental Health Center by the ~~Nebraska~~ Department of Health and Human Services, Division of Public Health.

35-004.03~~D~~B Bed Limitation: The maximum capacity for this facility ~~shall~~ must not exceed ~~eight~~ 16 beds. ~~Waivers to a maximum of ten beds may be granted when it is determined to be in the best interests of clients. Facilities under contract with the Department of Public Institutions prior to the promulgation of these regulations, whose capacity exceeds the ten-bed limitation, but which have no more than 15 beds, may be exempted from this requirement.~~ There ~~shall~~ must be no ~~other~~ waiver of this regulation over the ~~ten~~16-bed limitation.

35-004.03A Direct Care Staff: The Psychiatric Residential Rehabilitation program must have an overall 1:4 staff to client ratio of direct care staff during awake hours and at least one awake direct care staff during overnight hours. The program must have the appropriate staff coverage to provide services for clients needing to remain in the residence during the day. Staff to client ratios must be enhanced to meet client need when necessary.

35-004.03B Clinical Staff: Through employment or contract, the Psychiatric Residential Rehabilitation program must have the following consultants available:

1. Clinical Supervisor. The Clinical Consultant must participate in Individual Treatment and Recovery Plan development and provide clinical supervision, consultation, and support. The Clinical Consultant may also participate in client assessment. The Clinical Consultant must work with the program at least four hours per week.
2. Behavior Management Specialist
3. Other Consultants. Consultation by appropriately licensed professionals on general medical, psychopharmacology, and psychological issues, as well, as overall program design must be available and used as necessary.

35-004.04 Program Availability: The Psychiatric Residential Rehabilitation program must have the capacity to be staffed 24 hours per day, seven days per week according to client need.

~~35-004.03C Staffing Requirements:~~

35-004.05 Clinical Documentation: Residential Rehabilitation Service providers must follow the clinical documentation requirements listed in 471 NAC 35-001.06.

35-004.06 Therapeutic Pass Days: Therapeutic passes are an essential part of the rehabilitation process for clients involved in residential rehabilitation services. Documentation of the client's continued need for residential rehabilitation services must follow overnight therapeutic passes. Therapeutic passes must be indicated in the ITTP and ISP as they become appropriate. NMAP reimburses for 45 therapeutic pass days per client per year.

35-004.07 Hospitalizations: In the event that a client does require hospitalization while in a residential rehabilitation program, NMAP will reimburse the Residential Rehabilitative Program for up to 15 days per hospitalization. This reimbursement is only available if the rehabilitation placement is not used by another client and the client returns to the psychiatric rehabilitation bed occupied prior to hospitalization.

35-~~013~~005 Assertive Community Treatment: The Assertive Community Treatment (ACT) Team provides high intensity services, available to provide treatment, rehabilitation, and support activities seven days per week, twenty-four hours per day, 365 days per year. The team has the capacity to provide multiple contacts each day as dictated by client need. The team provides ongoing continuous care for an extended period of time, and clients admitted to the service who demonstrate any continued need for treatment, rehabilitation, or support will not be discharged except by mutual agreement between the client and the team.

Assertive Community Treatment (ACT) is provided by a self-contained clinical team which:

1. Assumes overall responsibility and clinical accountability for clients disabled by severe and persistent mental illness by directly providing treatment, rehabilitation and support services and by coordinating care with other providers;
2. Minimally refers clients to outside service providers;
3. Provides services on a long-term basis with continuity of care givers over time;
4. Delivers most of the services outside program offices;
5. Emphasizes outreach, relationship building, and individualization of services;
6. Provides psychiatric treatment and rehabilitation that is culturally sensitive and competent; and
7. Shares team roles expecting each staff member to know all the clients and assist in assessment, treatment planning, and care delivery as needed.

This model of integrated treatment, rehabilitation, and support services is intended to help clients stabilize symptoms, improve level of functioning, and enhance the sense of well being and empowerment. Services provided will focus on treatment and rehabilitation of the effects of serious mental illness, as well as support and assistance in meeting such basic human needs as housing, transportation, education, and employment ~~is~~ as necessary for client satisfaction with services and increased quality of life. The goal of the program is to provide assistance to individuals in maximizing their recovery, to ensure client directed goal setting, to assist clients in gaining hope and a sense of empowerment, and provide assistance in helping clients become respected and valued members of their community.

35-~~013~~005.01 Admission and Discharge Criteria

35-~~013~~005.01A Admission Criteria: NMAP covers ACT services ~~are intended~~ for those persons disabled by severe and persistent mental illness who are unable to remain stable in community living without high intensity services. ACT services must be prior authorized by the Department or its designee. To be eligible for ACT services clients must meet all of the criteria described in 471 NAC 35-001.01A, and demonstrate indicators of high need and utilization.

35-~~013~~005.01B Discharge Criteria: The ACT Program is intended to provide services over a long period of time. Clients admitted to the service who demonstrate continued need for treatment, rehabilitation, or support ~~will~~ must not be discharged except by mutual agreement between the client and the ACT Team.

Discharge~~s~~ from the ACT Team occurs when the client and program staff mutually agree to termination of services. Specific documentation must be included in the

client's clinical chart when a discharge occurs. See 471 NAC ~~35-004.04~~ 35-001.05. Discharge may occur in the following situations:

1. Geographic Relocation: The client moves outside the team's geographic area of responsibility. In such cases, the ACT Team must arrange for transfer of mental health service responsibility to a provider wherever the client is moving. To meet this responsibility, the ACT team must maintain contact with the client until this service transfer is arranged.
2. Significantly Improved Functioning: The client demonstrates by functional assessment measurement the ability to function in all major role areas (i.e., work, social, self-care) with minimal assistance.
3. Client Requested Discharge: Requested discharge despite the team's best efforts to develop a treatment and service plan acceptable to the client. Efforts to develop an acceptable Individual T~~t~~reatment Recovery Plan~~and service plan~~ must be documented in the client's clinical record.
4. Hospitalization of the Client in an Institute for Mental Disease (IMD): The NMAP is not able to reimburse for services provided to clients over age 20 and under age 64 who are being treated in an Institute for Mental Disease.

35-~~013~~005.02 Staff Requirements: Each ACT Team must provide a comprehensively staffed team, including a psychiatrist, a peer support person, and program assistants. The ACT Team must have among its staff individuals who are qualified to provide the required services. Each ACT Team must employ, at a minimum, the following number of clinical staff persons, peer support, and psychiatrists to provide the treatment, rehabilitative, and supportive services. Providers are responsible for verifying that staff are appropriately licensed or certified.

35-~~013~~005.02A Staff Qualifications: All clinical staff must be appropriately licensed or credentialed as required by the Department of ~~Regulation and Licensure~~ Health and Human Services Division of Public Health. All clinical staff must have at least two years of experience working with persons with serious and persistent mental illness. All clinical staff must maintain sufficient hours of continuing education to maintain certification or licensure.

35-~~013~~005.02B Background Checks: The employer of the ACT Team members is responsible and accountable for the activities and interventions of the ACT Team staff. The employer must consider which type of criminal background and Abuse/Neglect Central Registry checks are appropriate for their staff and how the results impact hiring decisions. The use of criminal background and Abuse/Neglect Central Registry checks must be describ~~ing~~ed in the employer's policy and procedure manual and ~~is~~ be available for review.

35-~~013~~005.02C Staff Configuration: The configuration of an ACT Team depends on the number of clients to be served. The ACT Team maintains a 1:~~8~~10 staff to client ratio. ~~(the Team Leader, Team Psychiatrist, and Peer Support are not included in the ratio.)~~

1. Minimum Staff Configuration: The following minimum staffing configuration must be met in each ACT Team regardless of the number of clients served. This configuration may serve up to ~~40~~ 50 clients. The

team must have at least one member who demonstrates competency in drug/alcohol abuse and dependence or is a ~~certified~~ licensed alcohol and drug ~~abuse~~ counselor. The clinical staff must include:

a. Team Psychiatrist: Psychiatric coverage at a minimum ratio of 16 hours per week. This psychiatry time must be spent exclusively on the ACT Team program activities. The minimum services which must be provided by the Team Psychiatrist are:
   (1) The initial in-depth psychiatric assessment and initial determination for medical/pharmacological treatment;
   (2) Treatment plan reviews;
   (3) Weekly clinical supervision; and
   (4) Participation in at least two daily meetings per week.

b. Advanced Practice Registered Nurse (APRN): An APRN may provide coverage for existing psychiatry time while not replacing the team psychiatrist responsibility in the above services, provided that the APRN:
   (1) Is practicing within his/her scope of practice;
   (2) Has an integrated practice agreement with the team psychiatrist;
   (3) Defines the relationship with the psychiatrist and provides a copy of the integrated practice agreement between the team psychiatrist and the APRN at the time of enrollment, prior to the initiation of services and at anytime the agreement is modified or terminated.

~~b~~c. Team Leader: Each ACT Team must have one full time Team Leader. The Team Leader must have at least a master's degree in nursing, social work, psychiatric rehabilitation, psychology, physician's assistant or is a psychiatrist. The Team Leader must have demonstrated clinical and administrative experience.

~~c~~d. Mental Health Professionals: Each team must have one full time Mental Health Professional~~s~~. A ~~Mental Health~~ Professional is defined as a person who has completed a Master's or Doctoral degree in a core mental health discipline, and has clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting.

~~d~~e. Nursing Staff: Each team must have ~~one~~ three full time Registered Nurse~~s~~.

~~e.~~f. Mental Health Worker: Each team must have one Mental Health Worker who meets one of the following qualifications:
   (1) Is a ~~Certified~~ licensed Alcohol and Drug ~~Abuse~~ Counselor;
   (2) Has a bachelor's degree in rehabilitation or a behavioral health field;
   (3) Has a bachelors' degree in a field other than behavioral sciences or have a high school degree, and has work experience with adults with severe and persistent mental illness or with individuals with similar human services needs; OR

~~f~~g. Additional Staff: Each team must have one additional full time staff person who meets the qualifications of the Mental Health Professional~~, Registered Nurse~~, or Mental Health Worker.

~~g~~h. Peer Support: Each team must have a half time coverage of peer support ~~coverage~~. This team member position must be a self-identified consumer of mental health services. The Peer Support staff must have training, experience, and ability to work with the team in carrying out appropriate aspects of the treatment and service plan. The Peer Support staff must have a bachelor's degree or a high school diploma and either work experience with adults with severe and persistent mental illness, or be able to demonstrate the motivation, learning potential and interpersonal characteristics necessary to benefit from on-the-job training.

~~h~~i. Support Staff: Each ACT Team must have at least one full-time support staff person.

2. Expanded Staff Configuration: If an ACT Team will serve more than ~~40~~50 clients, the following staff must be added:
   a. Registered Nurse: Teams serving more than ~~40~~50 clients must have ~~at least two~~ additional Registered Nurses to meet the nursing needs of the expanded popultion;
   b. Peer Support: Teams serving more than ~~40~~50 clients must have full time Peer Support;
   c. Team Psychiatrist: Teams serving more than ~~40~~50 clients must maintain additional psychiatric coverage of 2.6 hours for every eight clients; and
   d. Mental Health Professionals: Teams serving more than ~~48~~ 50 clients must have at least two Mental Health Professionals.
3. Additional Staff: Teams serving more than ~~40~~50 clients must maintain a minimum ~~1:8~~ 1:10 staff to client ratio. This ratio excludes the ~~Team Leader~~, Psychiatrist, and APRN, if used and ~~Peer Support~~ the program assistant. The configuration of the ACT Team must reflect the needs of the client population.

35-~~013~~005.02D Staffing Positions: Each ACT team must have qualified staff assigned to each of the following positions:

1. Team Leader: The Team Leader is the clinical and administrative supervisor of the team and has overall responsibility and accountability for assuring that the requirements and functions as stated in these regulations are met. The Team Leader also functions as a practicing clinician on the ACT Team. The Team Leader ensures that all clinical tasks are completed or rescheduled and manages team response to all emergencies or crisis situations in consultation with the Team Psychiatrist. This is a full time position.
2. Team Psychiatrist: The Team Psychiatrist functions must be provided by a psychiatrist who is Board-certified or Board-eligible on a full-time or part-time basis. The Team Psychiatrist position may be shared by more than one psychiatrist and/or an APRN (see 471 NAC 35-005.02C(a and b)). The Team Psychiatrist provides clinical services including psychiatric assessment, treatment plan development and approval, psychopharmacologic and medical treatment, and crisis intervention to all ACT Team clients. The Team Psychiatrist is available 24 hours per day and seven days per week for crisis management. The Team Psychiatrist works with the Team Leader to monitor each client's clinical status and response to treatment, provides staff clinical supervision, and participates in the development of all treatment and service plans.

The rate of reimbursement for ACT programs that provide psychiatric coverage with less than 16 hours of a psychiatrist's time (psychiatrist and APRN combination) will be adjusted accordingly. (Please see the fee schedule for procedure code and rate).

3. Advanced Practice Registered Nurse: If an ACT Team includes an APRN to provide services included as part of the required team psychiatrist hours, the APRN works collaboratively with the psychiatrist. An APRN is able to provide services, except for the mandatory services which must be delivered by the team psychiatrist as described in 471 NAC 35-005.02C(1a.). The Team Psychiatrist is readily available for consultation and direction of the treatment activities provided by an APRN, within his/her scope of practice. Psychiatric 24/7 coverage must be documented via a written agreement between the psychiatrist and the APRN. A copy of the agreement must be sent to Medicaid at the time of enrollment.

~~3~~4. Peer Support: The Peer Support staff ~~is~~ performs clinical work based on their credentials and abilities.

~~4.~~5. Team Member: Team Members carry out treatment, rehabilitation, and support interventions consistent with their training and scope of licensure.

~~5~~6. Program Assistant: The program assistant is a non-clinician responsible for working under the direction of the Team Leader to support all non-clinical operations of the ACT Team. This is a full time position and not considered in the staff to client ratio.

35-~~013~~005.02E Staff Functions: The ACT Team must perform the following functions:

1. Clinical Supervision: Clinical Supervision is regular contact between a designated senior clinical supervisor and a member of the ACT Team to:
   a. Review the client's clinical status,
   b. Ensure appropriate treatment services are provided to the client, and
   c. Review and improve the ACT Team member's service provision.

   Clinical Supervision may occur during Daily Team Meetings, Treatment and Service Planning Meetings, side-by-side and face-to-face supervision sessions, and through a review of the client's clinical record and in other appropriate activities. Clinical Supervision must be appropriately documented. The Team Leader and/or the psychiatrist is responsible for supervising and directing all ACT Team activities.
2. Crisis Intervention and Response: In addition to the client specific Crisis Intervention plans, the ACT Team must have a procedure to respond to emergencies and crises. This includes, but is not limited to, 24-hour crisis intervention availability.
3. Assessment: Initial and updated assessments of the client must be provided as described in 471 NAC ~~35-013.04A~~35-005.04A. Appropriate staff must be assigned to this function based on individualized client need. The client and his/her family (as allowed by client permission) must be involved in all assessments.

4. Treatment Planning: Initial and updated treatment plans must be developed as described in 471 NAC ~~35-013.04B~~35-005.04B. In addition to the Team Leader and Team Psychiatrist, appropriate staff must be assigned to this function based on individualized client need. One specific staff person must be designated to document the treatment plan for the clinical record. The client and his/her family (as allowed by client permission) must be involved in all treatment plans, treatment plan reviews, and treatment plan revisions.
5. Individual Treatment and Recovery~~, Rehabilitation, and Service~~ Plan Coordination: Individual Treatment and Recovery ~~Service~~ Plan Coordination is an organized process of coordination among the multi-disciplinary team in order to provide a full range of appropriate treatment, rehabilitation, and support services to a client in a planned, coordinated, efficient and effective manner, as outlined in the treatment and service plan.
6. Interventions Based on individualized client need and preference and ACT Team qualifications, experience, and training, ACT Team members must be assigned to provide the active treatment, rehabilitative, and supportive services described in 471 NAC ~~35-013.04C~~35-005.04C.

35-~~013~~005.03 ACT Program Organization

35-~~013~~005.03A Hours of Operation, Coverage, and Availability of Services: The ACT Team must meet the following regulations related to availability and scheduling.

1. Hours of Operation and Availability of Services: The ACT Team must be available to provide treatment, rehabilitation, and support interventions 24 hours per day, seven days per week, 365 days a year~~, 24 hours per day~~. The ACT Team must be able to:
   a. Meet the clients' needs at all hours of the day including evenings, weekends, and holidays,
   b. Provide services at the time that is most appropriate and natural for the client as described in the client's individualized treatment plan; and
   c. Operate a minimum of 12 hours per day and eight hours each weekend day and every holiday.
2. Psychiatric Coverage: Psychiatric coverage must be available at all times. If availability of the Team Psychiatrist during all hours is not feasible, alternative psychiatric backup (including the APRN) must be arranged. The covering psychiatrist or APRN must have an orientation to the ACT Team concept and be supportive of its services. The covering psychiatrist or APRN must be able to get client specific information from an ACT Team member.

35-~~013~~005.03B Service Intensity: The ACT Team services must be able to provide the level of service intensity as dictated by client need. Client need is determined through the severity of symptoms and problems in daily living and is documented in the client's ~~individualized treatment plan~~Individual Treatment and Recovery Plan.

35-~~013~~005.03C Place of Service: The ACT Team must provide most of the interventions and service contacts in the community, in non-office based settings.

35-~~013~~005.03D Shared Responsibility: The responsibility of the total client caseload is shared by the entire ACT Team, even though team members may serve as a primary contact for certain clients. Over time, every team member gets to know every client and every client gets to know every team member.

35-~~013~~005.03E Staff Communication and Planning: The ACT Team ~~will~~ must use systems and methods for continuous daily communication and planning. These must include:

1. Daily Organizational Staff Meeting: A Daily Organizational Staff Meeting ~~is~~ must be held to review the status of all program clients, update the Team on contacts provided in the past 24 hours and to communicate essential information on current events and activities as they relate to the interventions provided by the ACT Team.
2. Daily Team Assignment Schedule: The Daily Team Assignment Schedule must list~~s~~ all of the interventions that need to be provided on that day and the ACT Team member assigned to complete the intervention.
3. Daily Log: The Daily Log ~~is~~ must be used to document that a client review has occurred.
4. Client Weekly Contact Schedule: The Client Weekly Contact Schedule ~~is~~ must be a written schedule of all treatment, rehabilitation, and support interventions which staff must carry out to fulfill the goals and objectives in the client's treatment and service plan.
5. Individual Treatment and Recovery ~~Service~~ Plan Meetings: Individual Treatment and Recovery ~~Service~~ Planning Meetings ~~are~~ must be regularly scheduled meetings to identify and assess individual client needs/problems; to establish measurable long and short term treatment and service goals; to plan treatment and service interventions; and to assign staff persons responsible for providing the services~~. I~~if the client and their family are not able to participate, the meeting must include~~s~~ their input. Appropriate support ~~is~~ must be provided to maximize the participation of the client and their family. If necessary, the Individual ~~t~~Treatment and Recovery ~~Service~~ Plan should address any barriers to participation. The ACT Team ~~shall~~ must conduct Individual Treatment and Recovery ~~Service~~ Planning Meetings, under the supervision of the Team Leader and Team Psychiatrist.

35-~~013~~005.04 Program Components and Interventions: Operating as a continuous treatment and rehabilitative service, the ACT Team ~~shall~~ must have the capability to provide assessment, comprehensive treatment, rehabilitation, and support services as a self-contained clinical service unit. Services must be available 24 hours a day, seven days a week, 365 days per year. Services must be provided by the most appropriate ACT Team members operating within their scope of practice. Services must include, but are not limited to:

35-~~013~~005.04A Assessment and Evaluation

35-~~013~~005.04A1 Initial Admission Assessment: Prior to accepting the client for admission, the ACT Team must assess and determine the appropriateness of the client for admission to the ACT Team program. The assessment must include a review of clinical information and client interview and may include additional assessment activities.

35-~~013~~005.04A2 Comprehensive Assessment: The Comprehensive Assessment is unique to the ACT Program in its scope and completeness. A Comprehensive Assessment is the process used to evaluate a client's past history and current condition in order to identify strengths and problems, outline goals, and create a comprehensive, individual Treatment and Service Plan. The Comprehensive Assessment reviews information from all available resources including past medical records, client self report, interviews with family or significant others if approved by the client, and other appropriate resources, as well as current assessment by team clinicians from all disciplines. A Comprehensive Assessment must be initiated and completed within 30 days after the client's admission to the ACT program, according to the following requirements:

1. Each assessment area must be completed by staff with skill and knowledge in the area being assessed and must be based upon all available information, including client self-reports, reports of family members and other significant parties, written summaries from other agencies, including police, courts, and outpatient and inpatient facilities, interviews with the client, and standardized assessment materials.
2. The Comprehensive Assessment must include a thorough medical and psychiatric evaluation and must identify client strengths as well as problems. The assessment must gather sufficient information to develop an individualized client-centered plan.
3. The Comprehensive Assessment may be revised during a client's tenure in the ACT Program. Information may be added, revised, or clarified.

35-~~013~~005.04B Individual Treatment~~, Rehabilitation,~~ and Recovery ~~Service~~ Plan Development and Coordination: Individual Treatment and Recovery ~~Service~~ Plan Development and Coordination is a continuing process involving each client, the client's family, guardian, and/or support system as appropriate, and the team which individualizes service activity and intensity to meet client-specific treatment, rehabilitation and support needs. The written Individual Treatment and Recovery ~~Service~~ Plan documents the client's goals and the services the client will receive in order to achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services.

An Initial Treatment, Rehabilitation, and Recovery ~~Service~~ Plan must be developed upon the client's admission to the ACT Team.

The Comprehensive Individual Treatment, Rehabilitation, and Recovery ~~Service~~ Plan must be developed for each client within 21 days of the completion of the Comprehensive Assessment. This Individual Treatment, Rehabilitation, and Recovery ~~Service~~ Plan will be developed and revised according to the following regulations:

35-013005.04B1 Comprehensive Individual Treatment and Recovery, Rehabilitation and Service Plan Development: TheA Ccomprehensive Individual Treatment, Rehabilitation, and Recovery Service Plan is developed through an organized process of coordination among the multi-disciplinary team in order to provide a full range of appropriate treatment, rehabilitation, and support services to the client in a planned, coordinated, efficient and effective manner. The Comprehensive Individual Treatment, Rehabilitation, and Recovery Service Plan provides a systematic approach for meeting a client's needs, treatment rehabilitation, and support needs, and documenting progress on treatment, rehabilitation, and service goals.

The following key areas must be addressed in the Individual Treatment, Rehabilitation, and Recovery Service Plan based upon the individual needs of the client: symptom stability, symptom management and education, housing, activities of daily living, employment and daily structure, family and social relationships, and crisis support.

This plan must:

1. Iidentify the client's needs and problems.;
2. Llist specific long and short term goals with specific measurable objectives for these needs and problems.;
3. Llist the specific treatment and rehabilitative interventions and activities necessary for the client to meet these objectives and to improve his/her capacity to function in the community.;and
4. Iidentify the ACT Team members who will be providing the intervention.

The treatment and service plan shall must be developed in collaboration with the client and/or guardian, if any, and, when appropriate, the client's family.

The client's participation in the development of the Treatment and Service Plan must be documented. The plan must be signed by the client and the Team Psychiatrist.

35-013005.04B2 Comprehensive Individual Treatment, Rehabilitation, and Recovery Service Plan Reviews: The ACT Team must review and revise the client's Treatment, Rehabilitation and Service Plan every six months, whenever there is a major decision point in the client's course of treatment, or more often if necessary. The Team Psychiatrist, Team Leader, and appropriate staff from the ACT Team must participate in each Individual Treatment, Rehabilitation and Recovery Service Plan Review. The ACT Team must include the client in the review. Guardians and/or family members should be encouraged to participate, as allowed by the client.

The Individual Treatment and Recovery, Rehabilitation and Service Plan Review must be documented in the client's clinical record. This documentation must include a description of the client's progress and functioning since the last Individual Treatment, Rehabilitation and Recovery Service Plan Review, the client's current functional strengths and limitations, a list of attendees, the discussion related to the Individual Treatment, Rehabilitation and Recovery Service Plan, and any changes to the plan. The plan and review will be signed by the client and the Team Psychiatrist.

The signature of the Team Psychiatrist indicates this is the most appropriate level of care for the client and that the treatment, rehabilitative, and service interventions are medically necessary.

35-~~013~~005.04B3 Client and Family Participation: The ACT Team is responsible for engaging the client in active involvement in the development of the treatment/service goals. With the permission of the client, ACT Team staff ~~shall~~ must involve pertinent agencies and members of the client's family and social network in the formulation of treatment and service plans.

35-~~013~~005.04C Treatment, Rehabilitative, and Supportive Interventions: The ACT Team must be able to provide treatment, rehabilitative, and supportive interventions to clients assigned to the ACT Team. The interventions are categorized into three areas and the specific application of each type of intervention must be based on the client's specific goals and objectives. The interventions must address the needs identified in the Comprehensive Assessment. While there are no requirements that the client receive a minimum number of a specific categories of intervention, the client must receive the interventions that are appropriate for their needs.

All interventions must be performed by professionals acting within the appropriate scope of practice.

35-~~013~~005.04C1 Treatment Interventions:

1. Medical Assessment, Management, and Intervention: The ACT Team ~~will~~ must provide the interventions necessary to treat the client's psychiatric and physical conditions.
2. Individual, Family, and Group Therapy or Counseling: The ACT Team ~~will~~ must provide individual, family, and group therapy or counseling to assist the client to gain skills in interpersonal relationships, identify and resolve conflicts, and systematically work on identified individual goals. These interventions focus on lessening distress and symptomology, improving psychological defenses and role functioning, and increasing and reinforcing the client's understanding of and participation in treatment, rehabilitative services, and activities of daily living.
3. Medication: The ACT Team ~~will~~ must provide the prescription, preparation, delivery, administration, and monitoring, of medications.
4. Crisis Intervention: The ACT Team ~~will~~ must provide Crisis Intervention Services by assessing client needs that require immediate attention and initiate a resolution to the need.
5. Substance Abuse Services: The ACT Team ~~will~~ must provide Substance Abuse Services to assist the client in achieving periods of abstinence and stability. The interventions include, but are not limited to assessment, individual and group counseling, education, and skill development. The interventions should help the client:
   a. learn to identify substance use, effects, and patterns,
   b. recognize the relationship between substance use, mental illness and psychotropic medications, and
   c. develop motivation to eliminate or decrease substance use and coping skills or alternatives to minimize substance use.

35-~~013~~005.04C2 Rehabilitative Interventions:

1. Symptom Management Skill Development: The ACT Team ~~will~~ must provide Symptom Management Skill Development to help the client cope with and gain mastery over symptoms and functional impairments in the context of adult role functioning.
2. ~~Pre-~~Vocational Skill Development: The ACT Team ~~will~~ must provide ~~Pre-~~Vocational Skill Development that includes individualized assessment and planning for employment based upon functional assessment and the client's needs, desires, interests and abilities.
3. Activities of Daily Living and Community Living Skill Development: The ACT Team ~~will~~ must provide services to help the client rehabilitate their functional impairments and limitations related to activities of daily living and living in a community setting. The services will help clients carry out personal hygiene and grooming tasks, perform household activities, find housing which is safe and affordable, develop or improve money management skills, use available transportation, and have and effectively use a personal physician and dentist.
4. Social and Interpersonal Skill Development: The ACT Team ~~will~~ must provide interventions to help the client rehabilitate their social functioning. The goals include, but are not limited to improved communication skills, developing assertiveness, developing social skills and meaningful personal relationships, appropriate and productive use of leisure time, relating to others effectively, familiarity with available social and recreational opportunities and support groups, and increased use of such opportunities.
5. Leisure Time Skill Development The ACT Team ~~will~~ must provide interventions to rehabilitate the client's ability to use leisure time appropriately.

35-~~013~~005.04C3 Supportive Interventions:

1. Assistance: The ACT Team ~~will~~ must provide support services, direct assistance, and coordination to ensure that the client obtains the basic necessities of daily life. These necessities include, but are not limited to: medical and dental services, safe, clean, affordable housing, financial support, social services, transportation, legal advocacy and representation, education, employment, food, and clothing.
2. Support: The ACT Team ~~will~~ must provide support to clients, on a planned and "as needed" basis, to help them accomplish their personal goals, gain a sense of personal mastery and empowerment, and to cope with the stresses of day-to-day living. This includes interaction that focuses on decreasing distress, improving understanding and reinforcing the client's participation in services.

3. Family Involvement: The ACT Team will provide education, support and consultation to clients' families and other major supports, with client agreement and consent. The ACT Team must encourage family members and other major sources of support to be involved in the services received by the client unless prohibited by the client, through legal action, or because of confidentiality laws. This includes education about the client's illness and condition and the role of the family in the therapeutic process, intervention to resolve conflict, and ongoing communication and collaboration between the ACT Team and the client's family.
4. Positive Peer Role Modeling: The ACT Team will offer opportunities for positive peer role modeling and peer support including practical problem solving approaches to daily challenges, peer perspective on steps to recovery and support, mentoring toward greater independence, empowerment, and ability to manage severe symptomology.

35-~~013~~005.05 National Accreditation and Certification: Providers must be nationally accredited under specific ACT Team standards, such as CARF (Commission on Accreditation of Rehabilitation Facilities), or must be actively pursuing accreditation in order to be enrolled. Providers that are actively pursuing accreditation with a national body must submit their accreditation plan for consideration. Providers actively pursuing accreditation will be enrolled on a provisional status.

35-~~013~~005.06 Clinical Documentation Requirements: Records must be kept in accordance with Nebraska standards as outlined in ~~Title 204 NAC 5 004.05~~ 471 NAC 35-001.06~~, in Nebraska Medical Assistance Program 471 NAC~~, and in accordance with the national accreditation body surveying the provider. The clinical records for ACT Team services must include the following information:

1. Client identifying and demographic information;
2. Assessments and Evaluations;
3. Team Psychiatrist's orders;
4. Treatment, Rehabilitation and Service Planning;
5. Current Medications;
6. Progress and contact notes must be recorded by all ACT Team members providing services to the client;
7. Reports of consultations, laboratory results, and other relevant clinical and medical information;
8. Documentation of the involvement of family and other significant others; and
9. Documentation of transition and discharge planning.

35-~~013~~005.06A Discharge Documentation: Documentation of discharge from the ACT program must included.

35-~~013~~005.07 Performance Improvement and Program Evaluation: The ACT Team must have a performance improvement and program evaluation plan which meets the criteria for accreditation in the approved national accreditation organization. In addition, the program will participate in all aspects of statewide ACT evaluation projects.

35-~~013~~005.08 Provider Enrollment: An ACT Team must complete Form MC-19, "Medical Assistance Provider Agreement, " and submit the completed form and a program overview that addresses the requirements in these regulations to the Department for approval. The ACT Team must maintain written policies and procedures that document compliance with all of the standards and requirements in 471 NAC 35-004. The Department is the sole determiner of which providers are approved for participation in this program. The provider will be advised in writing when its participation is approved. Annual updates of enrollment may be required.

35-~~013~~005.09 Program Review: The ACT Team will be reviewed regularly by the Department or its designee.

35-~~013~~005.10 ACT Service Delivery Manual: For additional information about Assertive Community Treatment Services, please refer to the ACT Service Delivery Manual.

35-~~013~~005.11 Prior Authorization: Reimbursement for services from the ACT Team must be authorized by the Department or its designee.

35-~~013~~005.12 Telehealth: ACT Team interventions may be provided via telehealth when provided according to the regulations 471 NAC 1-006.

35-~~013~~005.13 Reimbursement and Billing Information: ~~For services provided on or after July 1, 2003,~~ NMAP pays for assertive community treatment services at established rates. Providers must follow these billing requirements:

1. Claims for services provided by the ACT Team must be billed on an appropriately completed Form CMS-1500 or the standard electronic health claim form Professional transition ASC X 12N 837 (see claim submission table 471-000-49);
2. Claims for ACT Team services must use the procedure codes determined by the Department; and
3. The unit of service for ACT Team reimbursement is one day.

35-~~013~~005.14 Hospital Admissions: In the event that a client requires hospitalization while receiving services from the ACT Team, NMAP will continue to reimburse the ACT Team services for up to 15 days per hospitalization. The ACT Team must maintain as much involvement with the client as possible, based on consumer preference and authorization to release information. This includes providing interventions to the client, participating in transition and discharge planning, and any other appropriate involvement.

35-~~013~~005.15 Limitations on the Reimbursement for ACT Team Services: The following situation limits NMAP reimbursement for ACT Team Services. Because regulations prohibit federal financial participation in the reimbursement of services to clients age 22 to 64 in an IMD (Institute for Mental Disease), clients who are admitted to an IMD for longer than 15 days may have their eligibility suspended.